

MDR Tracking Number: M5-04-3940-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 7-20-04.

Dates of service prior to 7-20-03 were submitted untimely per Rule 133.308 and will not be considered further in this decision.

The IRO reviewed medical necessity for level III office visit with manipulation, chiropractic manipulative treatment 98940 & 98943, level IV office visit.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. Consequently, the requestor is not owed a refund of the paid IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On October 26, 2004, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

No EOB: Neither party in the dispute submitted EOBs for some of the disputed services identified below. The requestor submitted convincing evidence that supports bills were submitted for audit. Since the insurance carrier did not raise the issue in their response that they had not had the opportunity to audit these bills and did not submit copies of the EOBs, the Medical Review Division will review these services per *Medical Fee Guideline*.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$ (Maximum Allowable Reimbursement)	Reference	Rationale
7-22-03 7-28-03 7-30-03	99213MP	\$54.00	\$0.00	No EOB	\$48.00	Medicine GR (I)(B)(1)(b) Rule 134.201	MAR reimbursement of \$48.00 X 3 dates = \$144.00 is recommended.
7-22-03	97110 (5)	\$225.00	\$0.00	No EOB	\$35.00/15min	Medicine GR (I)(A)(9)(b)	See Rationale below
7-22-03	97112	\$45.00	\$0.00	No EOB	\$35.00/15 min	Medicine GR (I)(A)(9)(b)	MAR reimbursement of \$35.00 is recommended.
7-22-03	97250	\$55.00	\$0.00	No EOB	\$43.00	CPT Code Descriptor	MAR reimbursement of \$43.00 is recommended.
7-22-03	97265	\$55.00	\$0.00	No EOB	\$43.00	CPT Code Descriptor	MAR reimbursement of \$43.00 is recommended.

7-30-03 8-20-03 10-14-03	99080-73	\$15.00	\$0.00	F	\$15.00	Rule 129.5(d)	TWCC-73s to support compliance with statute were not submitted, no reimbursement is recommended.
8-1-03 8-4-03 8-6-03 8-11-03 8-13-03 8-15-03 8-18-03 8-20-03 8-22-03	98940	\$35.00	\$0.00	No EOB	\$24.11 X 125% \$30.14	Rule 134.202	MAR reimbursement of \$30.14 X 9 dates = \$271.26 is recommended..
7-31-03	95900 (6)	\$384.00	\$0.00	No EOB	\$64.00/nerve	Medicine GR (IV)	Tibial, Peroneal and Plantar nerves were tested bilaterally. Reimbursement of 6 X \$64.00 = \$384.00 is recommended.
7-31-03	95935(6)	\$318.00	\$0.00	No EOB	\$53.00/extremity	Medicine GR (IV)	1 F-wave and 2 H-wave studies are reimbursable per MFG because symptoms were present in right lower extremity. 3 X \$53.00 = \$159.00 is recommended.
7-31-03	95904(8)	\$512.00	\$0.00	No EOB	\$64.00/nerve	Medicine GR (IV)	Sural, Saphenous, Plantar and Peroneal nerves were tested bilaterally. 8 X \$64.00 = \$512.00 is recommended.
7-31-03	95925(2)	\$350.00	\$0.00	No EOB	\$175.00/study	CPT Code Descriptor MFG Preamble	MAR reimbursement of \$43.00 is recommended.
8-6-03 8-8-03 8-11-03 8-13-03 8-15-03 8-18-03 8-20-03	98943	\$25.00	\$0.00	No EOB	NRF		
8-13-03 8-29-03	99178	\$22.00	\$0.00	No EOB	NRF		
8-28-03	99080 (154 pgs.)	\$77.00	\$0.00	F	\$0.50	Rule 133.106	MAR reimbursement of \$77.00 is recommended.
TOTAL							The requestor is entitled to reimbursement of <b>\$1711.26.</b>

#### Rationale for 97110:

Recent review of disputes involving one-on-one CPT code 97110 by the Medical Dispute Resolution section indicate overall deficiencies in the adequacy of the documentation of this code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one." Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the matters in light all of the Commission requirements for proper documentation. The therapy notes for these dates of service do not support any clinical (mental or physical) reason as to why the patient could not have performed these exercises in a group setting, with supervision, as opposed to one-to-one therapy. The Requestor has failed to submit

documentation to support reimbursement in accordance with the 1996 MFG and 133.307(g)(3). Therefore, reimbursement is not recommended.

### **DECISION & ORDER**

Based upon the review of the disputed healthcare services within this request, the Division has determined that the requestor **is** entitled to reimbursement for CPT codes, 99213MP, 97112, 98940, 99080, 97250, 97265, 95900, 95925, 95904, 95935 in the amount of **\$1711.26**. Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Division hereby ORDERS the Respondent to remit **\$1711.26** plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this Order.

The above Findings, Decision and Order are hereby issued this 28th day of January 2005.

Elizabeth Pickle  
Medical Dispute Resolution Officer

Medical Review Division

### **NOTICE OF INDEPENDENT REVIEW DECISION**

**Date:** September 10, 2004

**RE:**

**MDR Tracking #:** M5-04-3940-01

**IRO Certificate #:** 5242

\_\_\_\_\_ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to \_\_\_\_\_ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

\_\_\_\_\_ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a Chiropractic reviewer who has an ADL certification. The reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

#### **Submitted by Requester:**

- Clinical Notes dates 7/22/03-10/22/03 from \_\_\_\_\_,
- Health Questionnaire (Re-Exam) dates 8/29/03 and 7/28/03
- Quadruple Visual Analog Scale dated 10/14/03

- History of Present Illness (Re-Exam dated 8/29/03)
- Nerve Testing Charge Sheet dated 7/31/03
- Re-Exam Orthopedic & Neurologic Evaluation dated 7/28/03
- Exercise Log dates 7/22/03-7/25/03 from \_\_\_\_\_

### **Submitted by Respondent:**

- Correspondence Letter dated 8/30/03 from \_\_\_\_\_
- Peer Review dated 10/22/03 from \_\_\_\_\_.
- Required Medical Examination Report dated 2/27/04 from \_\_\_\_\_.
- Summary of Carrier Position dated 8/5/04 from \_\_\_\_\_
- Medical Dispute Resolution Request/Response
- Table of Disputed Services dates 7/7/03-10/22/03
- Case Review dated 7/5/03 from \_\_\_\_\_.

### **Clinical History**

I have had the opportunity to review the medical records in the above-mentioned case for the purpose of an Independent Review. The claimant injured her low back and right ankle when she reportedly tripped over a floor mat. The claimant has had treatment from multiple providers including \_\_\_\_\_ and \_\_\_\_\_. The treatment provided by \_\_\_\_\_ dates 5/12/03-10/22/03 included chiropractic manipulation with various physiotherapy modalities and active therapeutic exercises. The claimant has had diagnostic studies performed and based on the peer review for \_\_\_\_\_ this studies where with normal limits.

### **Requested Service(s)**

Level III office visit with manipulation, chiropractic manipulative treatment (98940 & 98943), Level IV office visit regarding the above-mentioned injured worker for dates 7/23/03-10/22/03.

### **Decision**

I agree with the insurance carrier that Level III office visit with manipulation, chiropractic manipulative treatment (98940 & 98943), and Level IV office visit regarding the above-mentioned injured worker is not reasonable and necessary 14 weeks post injury.

### **Rationale/Basis for Decision**

The billing code 99213 (level III office visit) is a office visit or outpatient visit for evaluation and management of an established patient which requires at least 2 of 3 key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity the provided documentation does not support this billing 14 weeks post injury. The billing code 98940 is a manipulation code for 1-2 regions which 14 weeks post injury for a lumbar sprain/strain is not reasonable and necessary using Official Disability Guidelines which allows up to 18chiropractic visits over 6-8 weeks post injury with evidence functional improvement of symptoms with a gradual fade to a home treatment program. Further treatment beyond 6-8

weeks post injury is not justified based on the negative diagnostic studies. The billing code 98943 is a manipulation code for extraspinal, one or more regions which 14 weeks post injury far exceeds what is allowed in the Official Disability Guidelines for a right ankle sprain/strain which allows 9 visits over 8 weeks plus an active self-directed home therapy program. The billing for 99214 is in office or outpatient visit for evaluation and management of an established patient, which requires at least 2 of these 3 key components: detailed history; a detailed examination; medical decision making of moderate complexity the provided documentation does not support this billing 14 weeks post injury.